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ABSTRACT

The practicum attempted to decrease inappropriate referrals to special education from parents and elementary teachers at a Louisiana elementary school through inservice training for teachers (N=19) and parents (N=43). Training focused on: (1) improving teachers' recognition of characteristics of attention deficit disorder (ADD) and learning disability (LD), (2) improving elementary teachers' general knowledge of intervention techniques for the ADD child in the classroom, and (3) improving parents' recognition of characteristics of ADD and management techniques in the home. Inservice training for teachers was conducted in groups and in dyads. Parents also received training in both large and small groups. Results indicated that both teachers and parents increased their understanding of LD and ADD characteristics and behavior management techniques as measured by pre- and post-intervention measures. In addition, after training, both teachers and parents were better able to differentiate between appropriate and inappropriate referrals using sample cases. The appendixes include a job description referral and screening forms, Louisiana evaluation timelines, a definition of "exceptionality," the required components of the individual evaluation, a listing of inappropriate referral concerns, eligibility requirements for learning disabled and attention deficit disorder, and the evaluation instruments used in the study. Approximately 35 references. (DB)

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Improving the Understanding of Attention Deficit Disorder by Parents and Teachers Through In-service Training

by

Maxine Desselle

Cluster XXXI

A Practicum I Report Presented to the
Ed.D. Program in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1989

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PRACTICUM APPROVAL SHEET

This practicum took place as described.

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This practicum report was submitted by Maxine Desselle under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved: Polly Peterson, Ph.D.
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July 19, 1989
Date of Final Approval of Report

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ABSTRACT

Improving the Understanding of Attention Deficit Disorder by Parents and Teachers through In-service Training. Desselle, Maxine, 1989: Practicum Report, Nova University, Ed.D. Program in Early and Middle Childhood. Descriptors: Special Education/ Attention Deficit Disorder/Hyperactivity/Attention Span/ Learning Disabilities/Causes/Solution/Treatment/Education Needs/Medication/Behavior Modification/Special Programs/ Elementary Education.

This practicum was designed to decrease the number of inappropriate referrals from parents and elementary teachers to the Special Education Department. The literature indicated that teachers and parents are confused regarding criteria for eligibility, characteristics of Attention Deficit Disorder and the characteristics of Learning Disability. Parents and teachers are also handicapped regarding a general knowledge of child management. Because teachers and parents are the primary referral source, this practicum was aimed at (1) improving elementary teachers' recognition of characteristics of Attention Deficit Disorder and Learning Disability, (2) improving elementary teachers' general knowledge of intervention techniques for the Attention Deficit Disordered child in the classroom, and (3) improving parents recognition of characteristics of Attention Deficit Disorder and management techniques in the home.

The writer conducted in-services at a designated elementary school where little or no provisions are made for education improvement. In-services were conducted in groups and in diads for teachers. In-services for parents were conducted in two groups (kindergarten, first and second grades and third, fourth and fifth grades). At these meetings parents were invited to attend small group sessions later. In addition, a local pediatrician volunteered to discuss the dilemma of medication and Attention Deficit Disorder at the in-services.

The data indicate that all 5 objectives were met. Parents and teachers appear to understand the characteristics of Attention Deficit Disorder and recognize the difference between Learning Disability and Attention Deficit Disorder. They also demonstrated a knowledge of management techniques for the Attention Deficit Disordered child and the criteria for eligibility for Special Education. Scheduled individualized sessions allowed for intensive feedback by all participants. Specifically, parents expressed an interest in future workshops, indicating an elevation in parents' involvement.

CHAPTER I

INTRODUCTION

Description of Work Setting and Community

This practicum was conducted in an elementary public school system located in a rural area on the parish (county) line. Because of the school's location few provisions for in-services are provided.

This school, which serves a population of approximately 282 from pre-school to the fifth grade, is the only elementary school within a 60 mile radius. The faculty and administration include a male principal, no assistant principal and a full time secretary. The 17 teachers on the faculty include 1 pre-school, 2 kindergarten, 2 first grade, 2 second grade, 2 third grade, 3 fourth grade, 2 fifth grade, 1 Chapter one, and 2 physical education teachers. In addition, 2 special education teachers who are generically certified and a speech therapist serve this school as well as a high school 3 miles away. A school nurse and an adaptive physical education teacher also serve this school and four others.

The population of the community where this school is located is approximately 2,050. The population is 55% whites of French and Italian background and 45% blacks with an equal distribution of Catholics, Baptists, Pentecostals, Methodists and Jehovah's Witnesses. The socioeconomic

makeup of the community ranges from low to middle income; all of the residents receive public assistance, and many live in the three housing projects in this community. Few of the residents have completed high school.

Most of the people in the community are small farmers; however, located on the levee that borders the river of this community is a segment of the population called "river rats." The phrase was coined because these people claim land that is officially owned by the federal government. The government does not use this land for any productive purpose because it is adjacent to the levee and because of the probability of the river overflowing. These people do not pay taxes. They live off the land with a supplemental income from fishing. Approximately 25 families reside along the river. These families often feud among themselves, making entrance into this area almost impossible if one does not belong. They make up their own rules and regulations that they live by.

This elementary school was the choice for conducting this practicum because of its location, the number of inappropriate referrals to the special education department and the enthusiasm of the principal for in-services.

Writer's work setting and role

The writer's work setting is the Department of Special Education Pupil Appraisal Services, located in a rural parish (County). Uniqueness of the work setting can be described as a multidisciplinary diagnostic team that involves cross-cutting

of the disciplines at the pupil appraisal assessment phase of the evaluation. Population of the staff is 19, including 8 assessment teachers, 6 psychologists, 4 social workers, 1 audiologist, 2 coordinators and 1 director. Speech therapists and adaptive physical therapists are assigned as needed.

The writer's role in the work setting is school social worker. Qualification for the position are a two year masters degree in social work with two years supervision on the job setting followed by an examination to fulfill license requirements (see Appendix A).

Responsibilities include acting as a liaison person between designated schools and the special education department. Specific responsibilities of the liaison person include screening referral forms from designated schools to the special education department. A teacher, parent or a principal can initiate a referral.

The referral consists of the students' demographic data, referral concerns, a review of the student's academic data and social performances, current attendance data, language and communication skills, performance on applicable statewide assessment and basic skills tests, motor proficiency conducted by the teacher, and documented parent/teacher communication relevant to the referral concern, and any other pertinent information (see Appendix B).

Along with screening referral forms, the writer also coordinates cases for diagnostic evaluations and re-evaluations. As coordinator, the writer is required to follow specific

procedures within a designated time frame required by the State Department in order to comply with P.L. 94-142 (see Appendix C).

Specific duties as a social worker include conducting parent social interviews in order to compile social histories, administering specific adaptive instruments to parents, directing support services to students with learning or behavior problems, crisis intervention and providing in-service training on selected topics to school personnel.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

The problem was that elementary school teachers and parents, who are the primary referral sources to the Special Education Department, were making a significant number of inappropriate referrals to the Department. The time and money wasted on inappropriate referrals impeded the Special Education Department. Thus, the needs of the child who does not meet criteria for eligibility were not being met in the classroom or in the home. The problem existed because the regular classroom elementary teachers and the parents were unaware of the eligibility requirements for special education services for the exceptionality of Learning Disabled. Both parents and teachers were unaware of the behaviors and symptoms unique to the Attention Deficit Disordered child at home and in the classroom; in addition, neither parents nor teachers were aware of ways of dealing with the Attention Deficit Disordered child. As a result, many referral concerns on the referral forms were indicative of behaviors and symptoms unique to the Attention Deficit Disordered child rather than the Learning Disabled child. Moreover, based on the type of referral concerns, teachers and parents did not have a clear understanding of the definition of Exceptionality (see Appendix D).

As a result, many students referred for learning

disabilities were, in fact, classified as no exceptionality and were not eligible for special education services. This created confusion and disagreement with diagnostic findings by the referring teacher, principal and parent.

Another difficulty resulting from inappropriate referrals was the time and personnel required to satisfy components for a complete diagnostic evaluation. In order to conduct an evaluation, a psychologist, educational consultant, speech therapist, school nurse and school social worker are needed (see Appendix E). The time lines for an evaluation range from 30 to 60 operational days.

Problem Documentation

The above lack of knowledge led to an overflow of inappropriate referrals. Latest available data during the 1986-87 school year indicated that 27 referrals were made and 6 of these referrals met criteria for eligibility. Thus 21 were inappropriate referrals.

TABLE 1 - Referrals and Eligibility

	1986/87 School Year	
Total Referrals	27	
Total Diagnosed a Learning Disabled	6	(22.2%)
Total Inappropriately Referred	21	(77.7%)

The majority of the referral concerns were behaviors common to ADD children, such as daydreaming, poor attention, poor school attendance, high distractibility, excessive talking

out of turn, acting before thinking, and being clumsy and fidgety (see Appendix F).

Causative Analysis

The documented data indicate that teachers and parents were confused over eligibility requirements for the exceptionality of Learning Disability as outlined in Bulletin 1508 (1983) of the State Education Department (see Appendix G). Teachers and parents were referring children who appeared to meet criteria for Attention Deficit Disorder as outlined in DSM III-R (1986) (see Appendix G). Attention Deficit Disorder is not an exceptionality and does not meet criteria required for special services. However, these children exhibit behavior problems that affect performance in the home and classroom.

Specifically, teachers were confused regarding referral concerns unique for the exceptionality of Learning Disabled. For example, referral concerns over significant behavior of talking out of turn and blurting out inappropriate answers are not criteria for a diagnostic evaluation, nor would an evaluation remedy the problem. Also, referral concerns of daydreaming, inattentiveness, being easily distracted or overly active do not constitute a proper referral for learning disability if the child does not exhibit specific academic difficulties in a specific area. These referral concerns appear to meet characteristics of Attention Deficit Disorder. Parents and teachers were unaware of the special problems ADD children have and ways of dealing with these children in the

home and at school. Parents looked to teachers for answers and the teachers looked to the Special Education Department for answers.

In retrospect, teachers and parents lacked knowledge regarding criteria for eligibility requirements for the exceptionality of Learning Disabled in order to make proper referrals. They were also confused between symptoms/behaviors indicative of ADD and LD for proper referrals. Thus, in order to make proper referrals, elementary teachers and parents should be able to distinguish between characteristics of LD and ADD. In addition, parents and teachers should be aware of behavior unique to Attention Deficit Hyperactive Disordered children and effective methods of dealing with these children.

Relationship of the Problem to the Literature

Definition of the exceptionality Learning Disabled as outlined in Bulletin 1508 of the Department of Special Education (1983) includes terms such as attentional deficit, perceptual handicaps, process disorders, minimal brain dysfunction, brain injury, dyslexia, developmental aphasia or sensory-motor dysfunction. However, to be classified as Learning Disabled, a student must exhibit an academic deficit in one of the following areas: reading recognition, reading comprehension, math calculation, math reasoning, oral expression, listening comprehension and written expression (spelling). Also, there must be a discrepancy between achievement as measured by the Woodcock-Johnson Psycho-

educational Battery and ability as measured by the Wechsler Intelligence Scale for Children - Revised (WISC-R) (see Appendix G).

Confusion lay in the definition of LD by the State Department that includes terms that also apply to ADD, but those terms alone are not used for eligibility requirements. Another factor that caused confusion among parents is that some local pediatricians report to parents that ADD is a learning disability and should receive special services. Not only were parents confused by the criteria for learning disabled, but they also faced the problem of managing a child whose behaviors they did not understand without support. Most typical children could be Learning Disabled by some criteria, according to Thurow, Ysseldyke and Cassey (1984).

Goldstein and Goldstein (1988) also report that because of the ADD child's impulsive, overaroused and inattentive behavior that child is in a constant state of disruption and confusion in the home. The ADHD child usually ends up the scapegoat in a family with several siblings. These children make everyone in their environment aware of their mental state by their sensitivity. As one parent reported "They wear their feelings on their shirt sleeve" and "carry a chip on their shoulder."

Parents react to ADD children with helplessness in dealing with their negative behaviors according to Silver (1987). Thus, parents style often aggravates the problem.

Murphy and Corte (1987) reported that the ADHD child's inability to profit from and to learn from previous mistakes often leads to troublesome family relations. They reported parents' quest for help: "Pinning a label on my son doesn't help him behave any better or make life easier either. Somewhere inside there is a little boy we love, but how are we going to help?" (p.1).

Barkley (1981) reported that parents encounter management problems with ADHD children in situations such as when asked to do homework, when the parent is on the phone or when the child is in public places.

Wender (1988) reported that parents need to know how to recognize the ADHD symptoms, refer appropriately and treat properly. He further reported on the parents' inability to manage the disruptive behavior of the child. Dr. Tom Jones (1988), a local pediatrician, uses the following phrase to describe ADHD to parents and children: "Your mind is like a T.V. without the antenna. Sometimes we need an antenna to focus in."

Attention Deficit Hyperactive Disorder is a term used to describe a group of children who have many problems in common, according to Silver (1987), Some are overactive and are called Hyperactive or Hyperkinetic, while others are Distractible. He also stated that ADD children with hyperactivity might be anxious only during specific times, for example, math period. A child who is distractible might have

difficulty staying on task which would affect academic performance.

The teacher's dilemma, according to Ross and Ross (1982), is that they find it hard to tolerate a real discrepancy between intellectual test scores and actual school performance. Teachers suggest that it would help if they knew the readily identifiable symptoms of ADD rather than having to rely on their own judgement. Teachers also need assistance to recognize problems that are often demonstrated by students with suspected LD according to Sears (1986). Regarding hyperactivity Simms (1985) states that elementary educators must be aware of the major aspects of hyperactivity and drug therapy to meet the needs of the hyperactive students.

The problem of the ADD children usually leads to a negative effect on teacher-pupil interactions because the child's performance varies greatly from day to day, state Goldstein and Goldstein (1988). They report that by the time the child reaches third or fourth grade, motivation is a contributing factor to academic performance because of repeated failure that results in helplessness. They also state that classic ADD children as described by teachers are "the first to have their hands raised in the classroom whether they know the answer or not."

Gerardi and Coolidge (1983) report that behavior problems were the primary reason for referral for children suspected of Learning Disability. Hayden, Smith, Hippel and Baer (1986)

acknowledged teachers reports that the child is like a "walking radar set." The child is constantly distracted by all the sights, sounds, and events in the environment, and unable to block out things that are unimportant. Draeger (1987) reports that ADD children exhibit an application deficit rather than the ability deficit unique to LD as a major contributor to poor classroom performance. This coincides with the definition outlined in the writer's State guidelines, which is an ability deficit for LD rather than an application deficit.

Dalby (1985) compared children with ADD and children with reading disorders (LD). He found LD children were more impaired in academic attainment and showed evidence of qualitative disturbance in reading and spelling. He found that ADD children showed no qualitative reading or spelling problems. Copeland (1981) also stated that ADD children consistently have more difficulty with tasks of memory and attention than do LD children.

Metzger and Freund (1986) report that the hyperactive child is more sensitive to external contingencies while the LD child is more sensitive to instructions. Accordingly Conte and Others (1984) state that ADD children exhibit deficits in sustaining attention whereas the LD child exhibits deficits in selective attention.

Brown (1982) reported that hyperactive children are

generally singled out first and identified for special services. Factors contributing to these children's being singled out include poor impulse control. Specifically, these children have difficulty with coming to attention, decision making and sustained attention.

The literature indicates the difficulties teachers and parents have in distinguishing characteristics of an ADD child and an LD child for proper referral. The literature also reflects classroom management and home management problems. The confusion is complicated by the fact that an LD child may be impulsive and hyperactive, but the primary disorder is psychological processing that affects learning. An ADD child exhibits behaviors such as hyperactivity, impulsivity and inattention that are associated with LD and affects academic performance. So the teacher has to determine what comes first " the egg or the chicken." Specifically, Thurlow, Ysseldybe, and Cassey (1984) report on the ambiguity of identifying criteria and disagreement among referring teachers regarding the definition of learning disability.

Scott (1987) suggests that early diagnosis of ADD is important and that teachers need to identify effective reinforcement strategies to deal with a child's impulsivity and hyperactivity. This is considered secondary intervention used to prevent further deficits.

Graden (1986) reported the national figures indicate that of 92 percent of the student population referred for an evaluation, 73 percent are found to be eligible for services. These figures indicate that 19 percent of the student population exhibit difficulties with academic performance who are not eligible for special services. Though these figures are lower than those of the writer, they support the data collected by the writer. The children that do exhibit behaviors that affect academic performance and peer and family relations require intervention strategies, other than special education, in the classroom and in the home.

The literature covers 21 recent empirical articles and studies related to the writer's problem. The literature justified the theoretical and practical importance of this problem. Specifically, the literature implies that if teachers and parents were more knowledgable regarding characteristics of ADD and criteria for LD, their referrals would be more appropriate. Also, the literature supports the idea that if teachers and parents are aware of specific intervention techniques to utilize in the classroom and in the home, the needs of the child who does not meet criteria for LD and who demonstrates characteristics of ADD will be better met.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The goal of this practicum was to decrease the number of inappropriate referrals to the Special Education Department and to elevate parental/teacher involvement. Expectations included an improved knowledge and awareness by teachers and parents regarding Attention Deficit Disorder and Learning Disability. Specifically, parents and teachers were to recognize problems associated with Attention Deficit Hyperactive Disorder, understand about the various causes and know the different approaches to treatment.

Behavioral Objectives

The following objectives were projected for the practicum.

Objective 1: Elementary teachers will recognize characteristics unique to ADHD and LD over a 3 month period.

Objective 2: Elementary teachers will develop a knowledge of intervention techniques to utilize with the ADD child in the classroom.

Objective 3: Parents will recognize characteristics unique to ADD during a 3 month period.

Objective 4: Parents will demonstrate a knowledge of management techniques to utilize with the ADD child in the home.

Objective 5: Following the 3 month implementation

period, teachers and parents will continue to demonstrate their knowledge of appropriate referrals.

Measurement of Objectives

All instruments were developed by the writer utilizing specific characteristics of Attention Deficit Disorder and Learning Disability that the writer observed in her professional setting and in her preparation for the in-services.

Objective 1 was measured by the Attention Deficit Disorder Questionnaire for teachers, the Attention Deficit Disorder Rating Scale and the Learning Disability Rating Scale.

The Attention Deficit Disorder Questionnaire listed 20 observational behaviors unique to the classroom. The Attention Deficit Disorder Rating Scale listed 19 observational behavior items. The Learning Disability Rating Scale listed 22 behavior items. The teachers were asked to rate the children's observable behaviors in their classroom from almost never to almost always.

Objectives 2 and 4 were measured by the evaluation form. This instrument was utilized for teachers and parents. In order to adequately assess whether the teachers and parents acquired a knowledge of intervention and management techniques, they were required to list specific techniques that they plan to utilize.

Objective 3 was measured by the Attention Deficit Disorder Questionnaire for parents. This instrument listed 22 observable behavior items that the parents were asked to use to rate their children's behavior in the home.

Objective 5 was measured by appropriate responses of teachers and parents to sample cases. These instruments were designed by the writer from types of previous referral concerns by the teachers and parents at the designated school. In order to adequately assess whether teachers could distinguish between appropriate and inappropriate referrals, two cases were appropriate (LD) and one was inappropriate (ADD). After reading each case, the teachers were required to decide whether the sample case was an appropriate referral and to explain why.

The cases the writer designed for the parents were different in content and in format from the teachers'. Of the three sample cases, two were inappropriate referrals (ADD) and one was appropriate (LD). Each case listed six intervention techniques to help the child that the parents were asked to choose from and circle. Of the six choices, one was a decision as to whether to refer the child to the Special Education Department.

These instruments were utilized for the pre and post tests.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

The literature outlines several solutions the writer may draw from in order to reduce inappropriate referrals. For example, in-service training conducted by Truskin (1985) regarding eligibility requirements for Specific Learning Disability and Emotional Disability reduced referrals by 50 percent.

. In attempting to improve the quality of referrals, Thurlow, Ysseldyhe, and Casey (1984) used a teacher checklist. Porger (1985) also provided teachers with a classroom assessment behavior rating scale sensitive to hyperactive children.

Perret (1986) suggests that a combination of approaches that include behavior modification, medication and counseling for parents and teachers. Perret's approach as well as the following approaches emphasize teachers' and parents' understanding of Attention Deficit Disorder.

Murphy and Corte (1987) provided a list of "Do's and Don't's" in dealing with the ADD child. Goldstein and Goldstein (1988) discuss a variety of suggestions to increase parental competence. They suggest that parents need a guide to management of ADD children. Silver (1987) states that the first step in solution strategy for increased awareness is for all aspects of ADD to be recognized by parents and teachers.

They suggest that parents and teachers must "build on the child's strengths rather than magnifying weaknesses."

An observational "red flag" checklist that can be utilized to call a parent or teachers' attention to behaviors that require monitoring is suggested by Hayden, Smith, Hippell and Gare (1986).

Duckham-Shoor (1980) conducted an experiment regarding behavioral alternatives to medication in treating hyperactivity, a behavioral program including both contingency management instruction for parents and self-control training for children. Results suggest that behavior therapy is an effective alternative to drug treatment.

After investigating the potential effect of behavioral parents training with 24 hyperactive children, Horn (1984) reports that results indicated a significant decrease in problem behaviors reported by parents.

Hill (1985) implemented behavioral management intervention in the home and at school. Results indicated a significant increase of the subjects' on task time.

Cognitive behavior modification procedures were implemented to elementary school guidance counselors, who then administered treatment to Attention Deficit Hyperactive Disordered children. Kirby (1982) stated that the results indicated the program did have an effect on attention and impulsivity.

Richardson (1986) conducted research that supports utilizing drug therapy (methylphinidate) to improve reading level in ADHD children. However, Martin and Martin (1984) advocate treating the whole child, instead of just medicating the child, by providing parent/teacher techniques. Still Gadow (1983) reports that teachers are often not included in referral, diagnosis or withdrawal of medication. Hinshaw (1984) reported that medication plus cognitive-behavioral self-evalution proved optimal as intervention techniques.

Recent research by Spencer (1988) demonstrated increased knowledge of teachers by providing in-service training. regarding eligibility requirement. Goldberg (1988) also reported an increase in quality of referrals after a dynamic 3 month in-service.

The Conner's Teachers Questionnaire is the best predictor to differentiate between children with ADD and children with LD, according to Keuhn, Cheryl and others (1988).
At a symposium on ADD Goldstein and Goldstein (1988) also utilized Conner's Hyperkinesis Questionnaire along with Barley's Elementary School Situation Questionnaire and Goldstein's Behavioral Observation Checklist as possible solution to improve the public's awareness of ADD. In order to distinguish between ADD children and typical children Brown (1986) provided teachers with the abbreviated Conner's Rating Scale. Also Yu-cun and others (1985)

utilized a standardized questionnaire with each suspected case of ADD to diagnose Attention Deficit Disorder.

Epstein and Niemien (1984) investigated the inter-rater and intra-rater reliability of Conner's Abbreviated Teacher and Parent Rating Scales. The Rating Scales appeared to have sufficient reliability to recommend its continued use to improve teachers' and parents' awareness of characteristics of ADD.

Another solution strategy that could be used to decrease inappropriate referrals of ADD is the Ozawa Behavioral Rating Scale for assessing ADD proposed by Ozawa and Michael (1984).

Research findings conducted by Brophy and Rohrkemper (1988) indicated that teachers rated higher by the principals expressed more willingness to become personally involved in working with problem students, more confidence in their ability to elicit significant improvement in the problem behavior, and a richer description of long-term prevention or solution strategies. The writer supports this finding in that this is an important step to alleviate dumping problem children on special services.

Evaluation of the possible solutions suggested in the literature indicates overall positive results with in-service training. Specific techniques were suggested to decrease inappropriate referrals and provide assistance to parents and teachers who deal with ADHD children. These techniques include rating scales, questionnaires, medication,

observational checklists, and behavior management training that the writer drew from.

In the writer's opinion, all of these techniques have achieved positive results and appeared workable in the designated population and were easily implemented in the writer's worksetting. In fact, these techniques produced better results than did the School Building Level Committee which had previously been set up to decrease inappropriate referrals. The Committee failed to decrease inappropriate referrals because the members -- principal, parents and teachers -- had never been trained to distinguish between criteria for Learning Disability and for Attention Deficit Disorder.

Description and Justification for Solution Selected

The literature provided strategies the writer drew from utilizing several techniques to improve the understanding of parents and elementary teachers regarding ADD. The writer's solution to the problem was to provide in-services for teachers and parents regarding Attention Deficit Disorder and Learning Disability eligibility reguirements for special services and intervention techniques for Attention Deficit Disordered children. This was the most appropriate solution because the teachers and parents had never been offered training at the designated school regarding appropriate and inappropriate referrals and such intervention techniques. A series of in-services over a 3 month period increased teachers' and parents' knowledge of behavior unique to ADD children. This knowledge should decrease both inappropriate referrals to the Special Education Department and inappropriate behavior.

Specifically, the writer utilized an Attention Deficit Disorder Questionnaire, an Attention Deficit Disorder Rating Scale, a Learning Disability Rating Scale, an Evaluation Form and six sample cases that were developed by the writer. Classroom and home intervention techniques were also provided through handouts and discussion (see Appendix I).

The literature outlined the above solution strategies to be successful. Specifically, Trustin (1985) reported a 50 percent decrease in inappropriate referrals. Hill (1985),

Kirby (1982) and Hinshaw (1984) suggested that a holistic approach to child management proved to be successful.

The target population at the designated school was those children who were suspected of having an Attention Deficit Disorder. These children have participated in the learning center and some have been evaluated in the past but did not meet criteria for Learning Disability.

There were 8 kindergarteners, 29 second graders, 26 third graders, 27 fourth graders, and 23 fifth graders. There were 19 teachers involved in the in-service. The in-service for parents was separate from the teachers' in-service, and 113 parents were invited.

Because of the large number of parents there were two groups. The first group were parents of kindergarten, first and second grades. The second group were parents of third, fourth and fifth graders. So the possible number of parents participating in the first group was 62 and in the second group, 76.

A letter was sent to the parents on the designated school's letterhead inviting them to have coffee and doughnuts at the school's cafeteria (see Appendix J). With the principal the writer decided that a semi-social setting rather than a "workshop" atmosphere was most conducive to reducing parent apprehension. The people in this area, because of their isolation and relatively low educational levels, are uncomfortable interacting with professional people. In the

writer's professional opinion any publicity or attempt to involve others in the community would inhibit the dialogue between parents and the writer.

The agenda for the parents was

1. Introduction and purpose
2. The ADD child at home
3. The ADD child and friends
4. What can parents do?
5. Home intervention techniques for ADD children
6. The dilemma of medication

Following the initial meetings, parents were invited to set up a schedule for no more than 10 small group meetings to discuss specific concerns.

Initially, the teachers attended three in-services as a group, then met with the writer in diads. The group in-services took place at the faculty meeting time. During the three in-services the agenda for the group was

1. What causes ADD?
2. ADD and the elementary school years
3. What can teachers do?
4. What to do in the classroom
5. Ideas for teachers' intervention
6. A word about medication

The writer worked with the teachers in diads during their free period each week. Specifics were covered regarding characteristics and criteria for LD along with intervention

techniques for the ADD child. Individual cases of children that were referred and did not meet criteria for LD were examined with each teacher. Significant problems unique to the ADD child or children in each teacher's class were addressed.

The rationale for conducting the in-service during the working day for teachers was to guard against a tired and unreceptive audience. The sessions were also conducted during the day for parents because the majority, being farm families, do not work outside the home.

Report of Action Taken

The first week of the implementation the writer sent one set of letters to the parents of kindergarten, first and second graders. An overview presentation on Attention Deficit Disorder and Learning Disability was conducted with the teachers. A pre-test was administered to the teachers utilizing the three case studies unique to classroom situations.

The second week of the implementation a local pediatrician volunteered to discuss the dilemma of medication and Attention Disorder. The writer and a contact person at the designated school make phone calls to parents as a reminder of the in-service. In addition, personalized reminders were sent home with each child.

The third week of the implementation an in-service was conducted with parents of kindergarten, first and second graders. After the in-service each parent was invited to attend an additional meeting to discuss specific concerns or

to return for the next scheduled meeting. A pre-test utilizing the three case studies for parents was administered prior to the in-service, and the post-test was administered by the end of the in-service, along with the Attention Deficit Disorder Questionnaire, and evaluation form.

The fourth week of the implementation, the writer met with teachers in diads and in individual conferences to discuss specific concerns. Letters were sent to parents of third, fourth and fifth graders.

The fifth week of the implementation the writer continued to meet with teachers on an individual basis. Phone calls were made as a reminder to parents of the up coming meeting.

The sixth week of the implementation the writer met with parents of the third, fourth and fifth graders. Some of the parents from the first in-service returned for additional information. The same procedure was conducted during this in-service as with the first, except that returning parents did not take the pre and post tests. During the sixth week the writer was approached by her contact person at the designated school to conduct an additional in-service for parents who were interested in ADD although their children do not participate in the learning center.

During the following 3 weeks of the implementation, the writer continued to meet with teachers on an individual basis. The teachers were in-serviced as a group during the tenth week of the implementation. A post-test was administered,

utilizing the three case studies, along with the Attention Deficit Disorder Questionnaire, the Attention Deficit Disorder Rating Scale, the Learning Disability Rating Scale and the Evaluation Form.

All group in-services for teachers were conducted at 2:00 p.m. with the permission of the principal and the superintendent. Two were conducted during their faculty meeting with one special meeting allowed. The teachers were more involved and enthusiastic than the writer expected. They provided a number of individual case studies that led to detailed discussion of intervention techniques. Several teachers requested return visits or met the writer in the hall to discuss a specific child.

Individual visits allowed for a great deal of verbal interaction. Even the secretary and cafeteria workers became interested as shown by their requesting the handouts.

Participation from the parents may appear to be small in number in regard to the number invited; however, the number of 43 participants is considered excellent for this area by the writer. Circumstances that may have inhibited parent participation include the following: (1) in March there was a computer workshop with parents, (2) in April, Open House, (3) in May, kindergarten registration. Overall, considering the unavoidable circumstances, the writer was satisfied with the quality and quantity of the participants. Specifically, the writer was approached by several parents and asked to

return during the summer months to conduct another workshop. The writer anticipates that workshops for parents regarding Attention Deficit Disorder will be ongoing throughout the 1989-90 school year.

Calendar Plan

March 19	Secured approval for Proposal
March 20-24 (Week 1)	Sent letters to parents. Overview presentation. Pre-test to teachers.
March 27-31 (Week 2)	Second in-service for teachers. Utilized local pediatrician.
April 3-7 (Week 3)	Third in-service; met with parents. Pre and post tests.
April 10-14 (Week 4)	Fourth in-service; met with teachers in diads and individually. Pre-school and kindergarten (three teachers).
April 17-21 (Week 5)	Fifth in-service; met with teachers. First grade (two teachers).
April 24-28 (Week 6)	Sixth in-service; met with teachers. Second grade (two teachers).

Progress Report to Advisor

May 1-6 (Week 7)	Seventh in-service; met with parents. Pre and post-tests.
May 8-12 (Week 8)	Eighth in-service; met with teachers. Third grade (two teachers).

May 15-19 (Week 9)	Ninth in-service; met with teachers. Fourth grade (three teachers).
May 22-26 (Week 10)	Tenth in-service; met with teachers. Fifth grade (two teachers).
May 29-June 2 (Week 11)	Eleventh in-service. Post-test teachers.
June 5-9 (Week 12)	Additional in-service with parents.
June 12-15	Compiled evaluation data. Phone conference with advisor.
June 19-30	Submitted report to advisor.
July 19	Practicum report approved and recommended for ERIC.
August	Disseminated abstract to Cluster 31 members; Principal of designated school; Director of Special Education, and to the Assistant Superintendent.

CHAPTER V

RESULTS, CONCLUSIONS, RECOMMENDATIONS AND DISSEMINATION

Results

The goal of this practicum was to decrease inappropriate referrals and elevate parental involvement. The overall objective was to improve teachers' and parents' understanding of Attention Deficit Disorder, Learning Disability and a knowledge of child management techniques.

A series of in-depth in-services conducted over a 3 month period achieved greater results than did the School Building Level Committee originally set up in the school because the training provided a framework from which all teachers and parents can work.

On the Attention Deficit Disorder Questionnaire (see Appendix H), on a scale of 1 (almost never) to 5 (almost always), most teachers rated items such as Item 3: "Does not finish assigned tasks but jumps to something else," Item 18: "Impatient with self and others," and Item 19: "Academic performance fluctuates from day to day" at either 4 or 5.

On the Attention Deficit Disorder Rating Scale (see Appendix H), Item 2: "Needs constant supervision" and Item 6: "Always in constant motion" were rated 4 by the highest number of teachers.

On the Learning Disability Rating Scale (see Appendix H), most teachers responded to Item 5: "Difficulty with reading

recognition," Item 6: "Difficulty with reading comprehension," Item 8: "Poor written expression," and Item 11: "Reads from right to left at 1 or 2. These responses of almost never are in response to items that deal with specific characteristics unique to Learning Disability. It is interesting to note that the responses to characteristics unique to Attention Deficit Disorder, such as Item 3: "problem retaining spelling words," Item 12: "unorganized," Item 14: "short attention," Item 15: "hyperactivity," Item 16: "rushes to complete work," Item 17: makes careless errors," and Item 18: "does not try" were all at level 3 or 4.

The responses indicate that the teachers were able to single out children in the classroom that exhibited characteristics unique to ADD rather than to LD. They responded at level 3 or 4 on the behavioral items and at 1 or 2 on the academic items. Tables 2, 3, and 4 provide illustrations of how each item was rated on the designated instruments.

Table 2

ADD Questionnaire-Teachers' Response for each Rating

Total Number of Teachers - 19

Rating	Frequency	Percentage
1	12	.63%
2	24	1.26%
3	54	2.84%
4	174	9.16%
5	113	5.95%

Table 3

ADD Rating Scale-Teachers' Response for each Rating

Total Numbers of Teacher - 19

Rating	Frequency	Percentage
1	10	.53%
2	22	1.18%
3	61	3.21
4	175	9.21
5	90	4.74

Table 4

LD Rating Scale-Teachers' Response for each Rating

Total Number of Teachers - 19

Rating	Frequency	Percentage
1	96	5.05%
2	165	8.68%
3	72	3.79%
4	67	3.53
5	17	.89

Regarding Objective 2, the results demonstrated that 79% of the teachers listed specific techniques on the evaluation form that ranged from "clear cut limits" for the ADD child in the classroom to "encouragement and praise." Techniques the writer considered general that were provided by the teachers include "behavior modification" and "all interventions presented." Table 5 indicates that most of the teachers did master a knowledge of intervention techniques.

Table 5

Teachers' Knowledge of Specific Intervention Techniques (EVALUATION FORM)

Total Number of Teachers - 19

	Mastery	Percentage
Specific Techniques	15	79%
General Techniques	4	21%

The results obtained indicate that parents recognized characteristics unique to ADD in some of their children (Objective 3). Items such as "Accidently runs into people and objects," "Knows spelling words at home but forgets at school," "Runs excessively in public places such as the grocery store," "Interrupts conversations," "Prefers to be in own room alone rather than with family members," and "Works well alone or with one adult on projects" are among those that most parents rated at level 4 and 5. These figures indicate a recognition of behavior characteristics of Attention Deficit Disorder by the parents. Some of the responses are questionable because the parents may have answered in such a way as to please the writer. Table 6 summarizes the results from Objective 3.

Table 6

ADD Questionnaire-Parents' Response for each Rating 1 (Almost never) to 5 (Almost always)

Total Number of Parents - 43

Rating	Frequency	Percentage
1	11	.26%
2	48	1.1 %
3	184	4.3 %
4	447	10.4 %
5	252	5.9 %

The results obtained from the Evaluation Form for Objective 4 confirmed the expectation that parents demonstrated knowledge of management of the Attention Deficit Disordered child in the home. Seventy-seven percent of the parents listed specific techniques that ranged from "setting a certain time for homework" to "clear direction." Nine of the parents listed "all" under specific techniques that the writer considered general. The writer provided assistance to the parents that had difficulty filling out the Evaluation Form. Table 7 provides a summary of the results obtained from Objective 4.

Table 7

Parents' Knowledge of Specific Intervention Techniques

Total Number of Parents - 43

	Mastery	Percentage
Specific Techniques	33	77%
General Techniques	9	21%
No Response	1	2%

The final objective of teachers' and parents' demonstration of their knowledge of appropriate referrals was accomplished. The teachers improved their knowledge of appropriate and inappropriate referrals on the three sample cases by 47 percent for Case 1, 26 percent for Case 2 and 68 percent for Case 3. The 100 percent accuracy on the post-test may have resulted because the writer used the same cases for the pre and post tests. The teachers may have remembered the cases as well as the answers. However, of particular importance is the 100 percent accuracy with the Case Study of Felix (Case 3) who was Attention Deficit Disordered. The pre-test indicated that only 32 percent of the teachers reponded correctly, but they increased their understanding by 68 percent on the post-test. Also, on the pre-test the reasons the teachers gave for referring this case to the Special Education Department

included "emotional disturbance," "behavior disordered," "learning disabled," "the teacher needs to know how to help this child," and "short attention span."

These results indicate that the teachers understand that a child with ADD characteristics is an inappropriate referral to the Special Education Department. Table 8 provides an illustration of the teachers' knowledge of appropriate and inappropriate referrals on the three sample cases.

Table 8

Teachers' Knowledge of Appropriate Referrals

(SAMPLE CASES)

	Total Number of Teachers - 19		
	Correct	Incorrect	Accuracy Percentage
CASE STUDY 1			
Pre-test:	10	9	53%
Post-test:	19	0	100%
CASE STUDY 2			
Pre-test:	14	5	74%
Post Test:	19	0	100%
CASE STUDY 3			
Pre-test:	6	13	32%
Post-test:	19	0	100%

The parents also improved their knowledge of appropriate and inappropriate referrals on Case 1 and Case 2 by 67 percent and 63 percent. On Case 3, however, the percentage of accuracy decreased from 84 percent for the pre-test to 53 percent for the post-test. Factors that can be considered as contributing to the decline in accuracy on Case 3 are (1), following the in-service, the parents appeared to be confused as the whether Case 3 was a good referral; on the pre-test, they had simply circled Item 1: "Refer to the Special Education Department" automatically. Since that answer was correct for Case 3, the parents accidentally scored a higher percentage on the pre-test and (2), this case may have been somewhat unclear and ambiguous. In the writer's professional judgement, Objective 5 was met for the parents.

Table 9

Parents' Knowledge of Appropriate referrals

	Total Number of Parents - 43		
	Correct	Incorrent	Accuracy Percentage
CASE STUDY 1			
Pre-test:	2	41	5%
Post test:	29	13	67%
CASE STUDY 2			
Pre-test:	5	38	13%
Post-test:	27	16	63%
CASE STUDY 3			
Pre-test:	36	7	84%
Post-test:	23	20	53%

Conclusion

An interpretation of the data suggests that all 5 objectives were met, indicating that the goal of reducing inappropriate referrals to the Special Education Department by improving teachers' and parents' awareness of Attention Deficit Disorder will be achieved in the coming school year.

The results confirmed the expectation that teachers and parents recognized characteristics unique to Attention Deficit Disorder and Learning Disability. They also demonstrated a knowledge of specific intervention techniques to utilize in the home and in the classroom. In Addition, based on the results obtained from the three sample cases, they demonstrated, with a high degree of accuracy, their knowledge of appropriate referrals.

In the literature review, it is evident that others have met with positive results in utilizing solution strategies similar to those developed by the writer. Namely, Murphy and Corte (1987), and Goldstein and Goldstein (1988) presented evidence of improved parents' and teachers' awareness of Attention Deficit Disorder. Also, utilization of a "red flag" checklist by Hayden, Smith, Hippel and Gare (1986) produced a desired outcome.

Since the objectives were met, practical implications indicate that parents and teachers are aware that they must work together in order to meet the child's needs in the home and in the classroom. Another implication is that parents and

and teachers from the designated school will share their knowledge with others, thus generating appropriate referrals to the Special Education Department. Yet another implication is that teachers and parents possess a list of intervention techniques that will benefit not only the Attention Deficit Disordered child but all children.

One unanticipated outcome resulted in a lower accuracy percentage on the post-test conducted with the parents on one sample case. Rewording that particular case to avoid ambiguity may have elicited a more accurate response. Also, unanticipated, was the return of some parents to the second parent in-service and the request for a summer in-service. These events suggest a higher degree of parent interest and involvement than the writer anticipated for this area.

Based on the evidence gathered from the data presented in the Results section, the writer concludes that teachers and parents are more aware of Attention Deficit Disorder characteristics and the intervention techniques that can be utilized to enhance these children's academic skills.

Recommendations

If others were to replicate this practicum the writer's suggestions are (1) utilizing different sample cases for pre and post tests, (2) guarding against any ambiguity built into the sample cases, (3) investigating what events are planned during the implementation phase to promote parent participation, (4) personalizing all parents' invitations with a phone call,

a note by the student, or a reminder note, and (5) using individual and diad sessions for the teachers that are effective and workable.

This practicum will be conducted on an ongoing basis at the designated school as requested by the principal. This project has stimulated interest and a series of workshops will be conducted in several schools in the writer's area as requested by her colleagues.

Dissemination

Copies of the practicum were made for the Director of Special Education, the principal of the designated school, Dr. Jones, and the Parish Assistant Superintendent of Schools.

The coordinator and members of Cluster 31 will be presented with a copy of the abstract.

This practicum will be presented at the annual parishwide Parent Involvement Conference for Chapter I as requested by interested personnel.

References

Barkley, R.A. (1981). Hyperactive children: a handbook for diagnosis and treatment: The Guilford Press.

Brophy, J., & Bohrkemper, M. (1988). The classroom strategy study: Summary report of general findings. (Research No. 187). Eric Documentation Reproduction Service No. ED 295-759).

Brown, R.T., (1986). The validity of teacher ratings in differentiating between two subgroups of attention deficit disordered children with or without hyperactivity. Educational and Psychological Measurement, 45, (3), 661-69.

Brown, R.T., & Wynne, M.E. (1982). Attentional processing and teacher ratings in hyperactive, learning disabled and normal boys. (Report No. 143). (Eric Documentation Reproduction Service No. ED 227-640).

Conte, R. (1984). Attention in atypical and average learners. Selective and sustained attention in attention disordered, learning disabled, and average learners and summary report. (Report No. 143). (Eric Documentation Service No. ED 253 023).

Copeland, A.P., & Wisniewski, N.M. (1981). Learning Disability and hyperactivity: deficits in selective attention. Journal of Experimental Child Psychology, 32, (1), 88-101.

Dalby, J.T., (1985). Taxonomic separation of attention deficit disorders and developmental reading disorders. Contemporary Educational Psychology, 10, (3), 223-34.

Diagnostic Statistical Manual III-Revised (1987). American Psychiatric Association , Washington D.C.

Draeger, S. & Others (1987). Visual and auditory attention performance in hyperactive children competence or compliance. Journal of Abnormal Child Psychology, 14, (3), 11-24.

Duckham-Shoor, L.A., (1980). Behavioral alternatives to stimulant medication in treating childhood hyperactivity: effects on school and home behavior. (Report No. 143) (Eric Document Reproduction Service No. ED 244 503).

Epstein, M.H., & Nieminen, G.S., (1984). Reliability of the Conner's abbreviated teacher rating scale across raters and across time: use with learning disabled students. School Psychology Review, 12., (4), 457-59.

Gerardi, R.J., & Collidge, P.G. (1983). Steps before the referral. Journal of Learning Disabilities, 16, (9), 534-536.

Goldberg, L.F., (1988), A program to increase early elementary teachers' referring behavior for all eligible special education students through multimedia in-service training. Nova University.

Goldstein, M., M.D., & Goldstein, S., Ph.D. (1988) The multidisciplinary evaluation and treatment of children with attention deficit disorders. Utah: Neurology, Learning and Behavior Center Symposium.

Graden, J.L., (1986, November). Referral and decision making for learning disabilities: Implications for needed directions. Counterpoint, p. 4.

Hayden, A.H., Ph.D. Hippel, C.S., Ph.D., Smith, R.K., M.A., Baer, S.A., M.A., (1986). Children with Learning Disabilities. D.C.: U.S. Department of Health and Human Services.

Hill, J.W., & Gourley, D.R. (1985). Interactive pharmacological and behavioral management of a hyperactive attention deficit disordered child in an elective pharmacy clerkship. (Report No. 143). Eric Documentation Reproduction Service No. ED 259 546).

Hinshaw, S., (1984). Cognitive-behavioral and pharmacological interventions for hyperactive boys: comparative and combined effects. Journal of Consulting and Clinical Psychology, 52, (5) 739-49.

Horn, W.F., (1985). An evaluation of a multi-method treatment approach with hyperactive children. (Report No. 143). (Eric Document Reproduction Service No. ED 252 033).

Jones, T. Personal Communication, January, 1989.

Kirby, E.A., & Horne, A.M., (1983). Cognitive-behavioral modification with hyperactive/attention deficit disordered children. (Report No. 143). (Eric Reproduction Service No. ED 226-563).

Kuehne, C., (1988). Differences between children with attention deficit disorder, children with specific learning disabilities, and normal children. Journal of School Psychology, 25, (2), 161-66.

Louisiana State Department of Education, Pupil Appraisal Handbook, Louisiana., 1983.

Martin, L.L., & Martin, S.L., (1984). Hyperactivity-characteristics, possible causes and intervention strategies. (Report No. 070). (Eric Document Reproduction Service No. ED. 245 483).

Metzger, M.A., Greund, L. (1986). Rule-governed and contingency-shaped behavior of learning-disabled, hyperactive, and nonselected elementary school children. (Report No. 143). (Eric Document Reproduction Service No. ED 269 155 .

Murphy, L., M.S. & Corte, D.S., M.S. (1987). Practical pointers for parenting handicapped children. Special Parent/Special Child. 3, (5) 2-8.

Ozawa, J.D., & Michael, .W.B. (1984). The concurrent validity of a behavioral rating scale for assessing attention deficit disorder (DSMIII) in learning disabled children. Educational and Psychological Measurement, 43, (2), 623-32.

Perrett, Y.M., M.S.W. (1986) Children with handicapps. Maryland: Paul H. Brooks Publishing Co.

Porges, S., (1985). Illinois classroom assessment profile: development of the instrument. Multivariate Behavioral Research, 20, (2), 141-59

Richardson,E. (1986). What is the role of academic intervention in the treatment of hyperactive children with reading disorders, Journal of Children in Contemporary Society 19 , (1-2), 153-67.

Ross, D.M., & Ross, S.A. (1982). Hyperactivity: current issues, research and theory. New York: John Wiley and Sons.

Scott, M.E., (1987). Attention deficit disorder (ADD). Digest # 445. (Report No. 143). (Eric Documentation Reproduction Service No. ED 287 261).

Sears, C.J. (1986), Mathematics for the learning disabled child in the regular classroom. Arithmetic Teacher, 33. (5). 5-11.

Silver, L.B., M.D. (1987). Attention deficit disorders. New Jersey: CIBA.

Simms, R.B. (1985). Hyperactivity and drug therapy: what the educator should know. Journal of Research and Development in Education, 18, (3), 1-7.

Spencer, D.M.S. (1988). Inservice training to aid the elementary classroom teacher in making appropriate referrals for special education services. Nova University.

Thurlow, M., Ysseldyke, J. & Casey, A. (1984). Teachers' perception's of criteria for identifying learning disabled students. Psychology in The Schools. 21, 349-355.

Trushin, B. (1985). A plan to reduce referrals for psychological evaluation in the south central area of Dade County schools. Nova University.

Wender, E.H. (1988). Attention deficit hyperactivity 'common' problem. Pediatic News.May

Yu-cun, S., (1985). An epidemiological investigation of minimal brain dysfunction in six elementary schools in Beijing. Journal of Child Psychology and Allied Disciplines, 26, (5), 777-87.

APPENDIX A

JOB DESCRIPTION: SOCIAL WORKER

Social Worker

Qualifications:

Meet all applicable Louisiana Standards for State Certification of School Personnel as prescribed in Paragraph 295 of Act 754 regulations.

Reports to: Director of Special Education and Coordinator of Special Education

Supervises: Client cases that are assigned

Job Goal:

The social worker shall be directly responsible to the Director of the Pupil Appraisal Center. He is to identify problems of exceptional children from the standpoint of home environment, physical, and emotional development where appropriate. The social worker shall make recommendations to school personnel, parent or guardian, and other agencies involved in working with the child.

Duties:

1. Secure pertinent information about the child referred, such as birth, physical, health, social and emotional development.

2. Identify the child's problems as seen by the parent or guardian. This should include problems relating to school, home, health, and social factors.

3. Identify the child's problems as seen by the school. This should include all academic and behavioral problems.

4. Through approved testing materials and observations, the social worker shall determine the child's level of functioning from the standpoint of emotional and social development.

5. Review all materials and make appropriate recommendations to assist the child with his problems.

6. Interpret findings and recommendations to parents or guardian, school personnel, and other agencies involved. A written summary of the diagnosis and recommendations will also be provided.

7. Assist in writing an Individual Education Plan whenever appropriate.

8. Assist Parish Placement Committee whenever appropriate.

9. Keep case material confidential.

10. Assist school personnel and parents with necessary help in order to carry out recommendations.

11. Utilize all available material, equipment, and facilities frequently in the teaching process to help the child assess.

12. Maintain accurate data on children, teachers, parents, and programs worked with.

13. Execute all policies of the St. Landry Parish School Board as directed by the handbook.

14. Care for all school properties, physical facilities, and industrial equipment used in helping teachers and parents.

15. Carefully document all activities including mileage, cases assessed, programs given, parents, school and gencies contacted.

16. Attend in-service workshops as mandated by the local policies as legislative acts as evidenced by attendance.

17. Participate in self-developmental activities such as, active membership in professional organizations, attendance at meetings, workshops, conventions, etc., whenever possible and continuously upgrading the position of the assessment person.

18. Promote the educational process as evidenced by the sharing of ideas and materials with other staff members.

19. Work in professional harmony with staff members and school administrators as evidenced by positive reports.

20. Use available means to keep abreast of trends, techniques, and teaching strategist as evidenced by teaching methods employed (Post graduate work is encouraged.)

21. Cooperate with parents and agencies for educationally related purposes as required when requested.

22. Give talks to civic and public organizations when requested to do so.

23. Strive to up-live the image of public education on a regular basis by keeping the general public informed of student and school programs as evidenced by the use of mass media, invitations, observations, etc.

24. Throughout the year, display concern for the vital interest of the community through special school activities.

25. The social worker will perform all other duties and responsibilities not listed as delegated by the Director of the Pupil Appraisal Center.

Terms of Employment: Twelve months

Evaluation: Criteria as established by School Board Policy

APPENDIX B

REFERRAL FORMS

☐ Initial ☐ Re-evaluation

LOUISIANA SCHOOLS
PUPIL APPRAISAL SERVICES
CHILD IDENTIFICATION

STUDENT:

I.D. # [redacted]

1. Name _____ (Last) (First) (Middle)
2. Residence _____ (No.) (Street)
   _____ (City) (State) (Zip Code)
3. Telephone _____ (Area Code) (Number)
4. Birthdate _____ (Month) (Day) (Year)
5. Age _____ (Years) _____ (Months)
6. Legal Guardian:
   - ☐ Parents
   - ☐ Mother
   - ☐ Father
   - ☐ Other _____ (Relationship)
7. Ethnic Background
   - ☐ Anglo (White)
   - ☐ Black
   - ☐ Native American Indian _____ (Tribe)
   - ☐ Hispanic
   - ☐ Asian–Pacific Islander
   - ☐ Other _____
8. Sex: ☐ Male ☐ Female
9. Primary Language _____
   Child's first acquired language
   _____
   Language most often spoken by student
   _____
   Language most often spoken in the home

PARENT(S)/GUARDIAN:

10. Name _____ (Last) (First) (Middle)
11. Address _____ (IF DIFFERENT FROM ABOVE) (No.) (Street)
    _____ (City) (State) (Zip Code)
12. Home Phone _____ (Area Code) (Number)
    Work Phone _____ (Area Code) (Number)
13. Live with child: ☐ Yes ☐ No
14. Marital Status:
    - ☐ Married ☐ Divorced
    - ☐ Separated ☐ Unknown

SCHOOL:

15. Name _____
16. Address _____
17. Telephone _____ (Area Code) (Number)
18. _____ (Grade/Class)
19. Current Educational Program
    ☐ None ☐ Regular ☐ Special
20. _____ (How long in present school)

Current Placement:
- ☐ Regular Class
- ☐ Regular Class with Services
- ☐ Special Class
- ☐ Cooperative Program
- ☐ District No. 1
- ☐ Non-public Program
- ☐ Pre-school Program
- ☐ Day Care Program
- ☐ Not in School

Interpreter Needed: ☐ Yes
Surrogate parent needed: ☐ Yes

Initiated by: ON: _____ (Date)
- ☐ School
- ☐ Parent(s)
- ☐ Public Agency
- ☐ Private Agency (Specify)
- ☐ Other _____ (Specify)

How did you learn about this office? _____

Notification of Identification
- ☐ Parent/Guardian
  Date _____
- ☐ Sp. Ed. Supervisor
  Date _____

Date of Screening
_____ To _____

Screening Decision:
- ☐ Regular Classroom
- ☐ Educational Assessment Program
- ☐ Individual Evaluation

Date of Decision _____
- ☐ Report Sent to Sp. Ed. Supervisor
  Date _____
- ☐ Report to Parents
  Date _____

Child Search Coordinator or Designee
_____ (Signature)

REFERRED BY: (Optional Unless Teacher)

21. Name _____
22. Position _____
23. How long have you known student? _____
24. In what capacity? _____

25. Reasons for concern: _____

26. ☐ Other pertinent information attached.

EVALUATION FILE

SCHOOL BUILDING SCREENING

Student _____ Birthdate _____
Last First Middle Month Day Year

Parent _____ Teacher _____ Grade _____
Last First

Screening is a process of collecting and reviewing information about the physical, learning or behavior characteristics of individuals birth through 21 for the purpose of identifying those who are possibly exceptional.

A. REVIEW OF SENSORY SCREENING EDUCATIONAL.

DATE

Screening: (If no record, schedule immediate screening.) Complete the following:

Vision Results ☐ Normal ☐ At risk _____ Date of Screening ☐ Corrected _____

Hearing Results ☐ Normal ☐ At risk _____ Date of Screening ☐ Corrected _____

Academic Grade Progression: In each grade level block, specify: P (Pass), F (Fail), S (Social Promotion). There may be more than one letter in a block.

Promotion													
GRADE LEVELS	K	1	2	3	4	5	6	7	8	9	10	11	12

2. Academic Performance: List the last achievement test scores recorded for student. Give results of Statewide Assessment Test. List the final report card grades for the last two years of school attendance and grades received so far this year.

a. Date of Testing _____

Name of Test _____

	% File	Norm	Grade Level
Total Reading			
Total Language			
Total Math			
Science			
Social Studies			

b. Statewide Assessment Test

Date of Testing _____

Reading _____

Math _____

Writing _____

c. Report Card Grades

	PREVIOUS YEAR		PRESENT YEAR
Total Reading			
Total Language			
Total Math			
Science			
Social Studies			
Days Absent			

If prior evaluation, Date _____ Attach Report of Evaluation or Case Number and Current IEP.

B. REVIEW OF ACADEMIC AND SOCIAL PERFORMANCE, LANGUAGE, AND COMMUNICATIVE SKILLS AND MOTOR PROFICIENCY BY THE STUDENT'S TEACHER(S).

Functional Levels: Plot your judgement of the grade level where student is functioning in your classroom. Connect the plotted points. Indicate the student's actual grade placement by drawing a horizontal line across the graph. Departmentalized teachers might find it beneficial to confer with child's other teachers.

	Word Attack Skills	Reading Vocabulary	Oral Reading Comprehension	Silent Reading Comprehension	Listening Comprehension	Oral Expression	Written Language	Use of Reference	Spelling	Handwriting	Mathematics Facts	Math Skills/Computation	Math Word Problems	Science Concepts	Social Studies Concepts	Map/Graph Skills	Problem Solving Skills
14																	
13																	
12																	
11																	
10																	
9																	
8																	
7																	
6																	
5																	
4																	
3																	
2																	
1																	
K																	
PK																	

Attach and date any pertinent samples of student's work. (Check the appropriate box if attachments are included).

☐ Additional Information ☐ Work Samples

4. **Student Evaluation.** Please check the column to indicate how the student rates most of the time according to the following scale:

1. Poor 3. Average 4. Above Average
2. Below Average 5. Excellent

	1	2	3	4	5
Gross Motor Development					
Fine Motor Development					
Motor Coordination					
Creativity					
Attention Span					
Work/Study Habits					
Self-Motivation					
Attitude Toward School					
Observance of School Rules					
Peer Group Participation					
Attitude Toward Peers					
Leadership					
Self-Concept					
Maturity (For Age)					
Reaction To Stress					
Attitude Toward Adults					
Politeness					
Body Care					
Clothing Care					
Safety Awareness					
Responsibility					
Family Relationships					

COPY 1 & COPY 2 - Stay in Cumulative Folder if Regular Education Program is Checked
COPY 2 - Cumulative Folder if Referred to Director of Special Education is Checked
COPY 1 - Special Education Folder if Referred to Director of Special Education is Checked

GENERAL HEALTH HISTORY Name: _____ DOB: _____

Explain any Yes answers to the following questions.

Does the student	YES	NO	COMMENTS	Additional Information Attached CHECK
a. have recurring health problems?				
b. regularly take medication?				
c. have a known medical problem?				
d. have a physically crippling condition?				
e. appear to be chronically ill?				
f. wet/soil his clothes?				
g. receive professional treatment?				
h. receive school help for problems?				
Immunizations lacking?				

MOTOR - Is there a question of motor proficiency interfering with participation in a regular physical education program? _____Yes _____No
If yes, why?_____

TEACHER/PARENT COMMUNICATION

TYPE: _____letter _____telephone _____interview DATE:_____

AT LEAST ONE REGULAR EDUCATION INTERVENTION OR ADJUSTMENT APPROPRIATE TO THE STUDENT'S AGE AND LEARNING/BEHAVIOR PROBLEMS, PREVIOUSLY PERFORMED BY A CLASSROOM TEACHER.

1. ___Remedial or compensatory education; 2.___Retention;
3. ___Instructional methodology or curricular change;
4. ___Behavior management programs; 5.___School/Teacher schedule changes;
6. ___Other (Specify)

REVIEW OF INITIAL SCREENING INFORMATION

SBL COMMITTEE CHAIRPERSON:_____ DATE:_____
SBL MEMBERS:_____ _____
_____ _____
_____ _____

COMMITTEE RECOMMENDATION OR ASSISTANCE TO THE TEACHER(S) FOR REGULAR EDUCATION INTERVENTIONS OR ADJUSTMENTS:

PROBLEM	INTERVENTION	PERSON(S) RESPONSIBLE

THE SCHOOL COMMITTEE REFERRAL SHALL BE MADE THROUGH THE PRINCIPAL TO PUPIL APPRAISAL SERVICES AND SHALL INCLUDE DOCUMENTATION OF ALL SCREENING ACTIVITIES.

Recommendations for further attempts to answer concerns should be:

_____Regular Education Program _____ Referred to Director of Special Education

_____ _____ _____
Principal or Designee SBL Chairman Date

COPY 1 & COPY 2 - Stay in Cumulative Folder if Regular Education Program is Checked.

COPY 2 - Cumulative Folder if Referred to Director of Special Education is Checked.
COPY 1 - Special Education Folder if Referred to Director of Special Education is Checked.

COPY 1

APPENDIX C

EVALUATION TIMELINES

2. Any extensions of the individual evaluation timeline must be explained and documented in the individual evaluation report.

3. If a participating appraisal person disagrees with the conclusion(s) in the integrated report, that person may submit a separate signed dissenting opinion stating the disagreement, giving supporting data and conclusion(s) prior to the IEP meeting.

J. Evaluation Timelines

1. There shall be a period of no more than 10 operational days from the date of the receipt of referral for an individual evaluation of an identified student by pupil appraisal to the date when the request is made for parental approval to conduct the individual evaluation.

2. The evaluation report must be completed and disseminated within 60 operational days of receipt of parental approval unless a justified extension of time is required as specified.

3. An extension of time of no more than 30 operational days is permitted when:

   a. The evaluation coordinator and the student's teacher(s) determine that the pupil appraisal assessment program should be extended.

   b. Unusual circumstances, such as illness of the student, illness of a member of the student's family, or of the pupil appraisal person working with the student, interrupt the completion of the individual evaluation.

   c. The student has received an individual evaluation within the past three years, but the report has not yet been received by pupil appraisal services.

4. An extension of time of no more than 60 operational days is permitted when:

   a. Specialized diagnostic assessment and/or medical assessment services not available in the school system are necessary for the completion of the individual evaluation.

b. Natural disaster or catastrophe interrupts the completion of the evaluation. Such extensions must have prior approval from the State Department of Education, Office of Special Educational Services.

5. The maximal number of days of the extension described in 3 and 4 above shall not exceed the duration of the circumstance(s) necessitating the extensions.

6. Whenever formal parental approval for the initial evaluation of a student who is suspected of being exceptional is received within 30 operational days of the end of the school year, the evaluation coordinator may postpone the initiation of the evaluation to the first week of the next school year, or initiate the evaluation if it appears that the requirements of §436 of the Act 754 Regulations can be met. If the decision is to postpone or if the process, once initiated, cannot be completed, parents shall be given full and effective notice. If the process once initiated cannot be completed prior to the end of the school year, the evaluation may be completed during the next school year, as long as the total time required for the completion of the evaluation does not exceed 60 operational days, excluding that period during the summer when the regular school program is not in session.

7. Whenever the evaluation process initiated for any student within 59 operational days of the end of the school year cannot be completed prior to the end of the school year, the completion of the evaluation may be postponed until the next school year as long as the total time for the completion of the evaluation does not exceed 60 operational days, excluding that period during the summer when the regular school program is not in session.

8. Any extensions of the individual evaluation timeline must be explained and documented in the individual evaluation report.

IV. INTERIM PLACEMENTS FOR EVALUATION PURPOSES

Students who have been receiving special education in another state or school system within the State and children who possess a severe, low-incidence impairment documented by a qualified professional may be initially enrolled in a

special education program concurrent with the completion of the evaluation according to the requirements of Bulletin 1508. The enrollment shall occur only after:

1. Approval by the supervisor of special education,

2. A review of all evaluation information by pupil appraisal personnel,

3. The development of an interim IEP in accordance with §440-446 of Act 754 Regulations, and

4. Obtaining formal parental approval for the temporary placement.

The duration of time for the completion of the evaluation and interim placement shall not exceed the evaluation timelines specified in section III "J", with the initial IEP developed within 30 calendar days of the completion of the evaluation.

APPENDIX D

DEFINITION: EXCEPTIONALITY

DEFINITION OF EXCEPTIONAL

For a child to be considered an exceptional child under the Regulations Implementing Act 754, two conditions must exist.

First, the assessment data must indicate that:

1. An impairment is present, or
2. A requisite is present, such as exceptionally high abilities.

Second, an assessment of the current and past learning environment and the educational progress of the child must demonstrate a need for special educational services.

Only when both of the above are true is the child considered exceptional. Misclassification can occur in evaluating children by assuming that:

1. All impaired children need special educational services, or
2. All children with educational needs are exceptional.

APPENDIX E

COMPONENTS OF THE INDIVIDUAL EVALUATION

(8) A copy of the integrated report, including any dissenting opinions, and an opportunity for an oral explanation of the findings and recommendations are provided to the student's parent(s). This shall be done prior to the IEP meeting for an exceptional student.

(9) A pupil appraisal staff member who participated in the evaluation is designated, when necessary, to attend the IEP Committee meeting to assist in the development of the IEP.

F. Components of the Individual Evaluation

An individual evaluation that determines a student to be exceptional must consist of all required components of the Pupil Appraisal Assessment Program and/or Diagnostic Assessment as specified below and for each specific exceptionality. However, it is permissible to determine a student to be nonexceptional on the basis of selected components of the Pupil Appraisal Assessment Program or Diagnostic Assessment. The components of the individual evaluation may be conducted concurrently or separately.

1. Pupil Appraisal Assessment Program

The Pupil Appraisal Assessment Program is a process of assembling information about a student, through informal procedures or techniques, to assist in determining if a student may be classified as exceptional in accordance with Act 754 Regulations and this Bulletin. The program is classroom-based, and conducted by pupil appraisal staff working in conjunction with the student's teacher(s). It should generally be conducted prior to diagnostic assessment.

The Pupil Appraisal Assessment Program may be provided for any individual student but is required by the Criteria for Eligibility for specific exceptionalities. Exceptions may be made only when it is documented in the individual evaluation report that interventions and adjustments in the regular program have been exhausted or are impractical because of the severity of the student's difficulties or because available data indicate that the student is not handicapped. Information justifying such exceptions and enabling the

determination required in (g) below shall be included in the individual evaluation report.

The Pupil Appraisal Assessment Program shall include the following:

a. Sensory screening, if not previously conducted.

b. A review of the student's educational, social and medical history, including the attendance record.

c. An interview with the student.

d. A family interview.

e. An interview with the student's teacher in order to specify and behaviorally define the areas of concern, determine the teacher's expectations for the student and class, and clarify any previous interventions.

f. Observation and study of the student's academic and/or social behaviors in daily activities conducted by pupil appraisal personnel.

g. The development and implementation of individual interventions which must be conducted or directed by pupil appraisal personnel for a reasonable period of time.

(1) Individual behavioral interventions are designed to improve or determine if sufficient improvement can be made in the student's behavior in the regular classroom with regular education modifications and/or support services, or

(2) Individual instructional interventions are designed to determine whether the student learns (e.g., acquisition, comprehension, retention) like a handicapped or nonhandicapped student.

NOTE: Individual interventions consist of techniques such as:

- Restructuring the classroom/school environment,
- Peer tutoring,

- Classroom-based reinforcement technique,
- Behavior modification/therapy in the classroom,
- Combined home/school behavior change program,
- Individual or group counseling/therapy, or
- Modification of the curriculum and/or instructional approach.

h. Systematic measurement of academic and/or social behaviors of concern conducted prior to and following implementation of the intervention, or prior to with repeated measures during the intervention.

i. An analysis of the results of the individual intervention(s).

When the Pupil Appraisal Assessment Program is prolonged because of the nature of the intervention(s), the student's parents should be given periodic progress reports.

2. Diagnostic Assessment

Diagnostic Assessment includes those procedures, instruments, and sources of information used to assist in determining if a student may be classified as exceptional in accordance with Act 754 Regulations and the criteria specified in Bulletin 1508.

a. The required Diagnostic Assessment is specified in the evaluation procedures for each exceptionality and may include but is not limited to such activities as:

(1) Classroom observation.

(2) Educational, developmental, and adaptive behavior assessment.

(3) Psychological, psychiatric, social, and medical evaluations.

(4) Interviews with parents and teachers.

(5) Speech and language evaluations.

(6) Other evaluations determined to be necessary by the evaluation coordinator.

b. All diagnostic assessments shall be conducted according to the following standards.

(1) No single procedure may be used as the sole criterion for determining an appropriate educational program for the student. A variety of instruments, procedures, and sources of information shall be used.

(2) Tests and other evaluation procedures and materials shall be:

(a) Tailored to assess specific areas of educational need.

(b) Recommended by their producer and validated adequately for the specific purpose(s) for which they are used.

(c) Appropriate for the age and stage of development of each person to whom they are administered.

(d) Used in such a manner as to be free of racial, cultural, language, or sex bias. In no event shall an IQ score be reported or recorded in any individual student's individual evaluation report.

(e) Written and administered in the native language or conducted in the mode of communication most familiar to the person being assessed (e.g. nonverbal intellectual assessment of deaf students), unless it can be demonstrated that it is infeasible to do so.

(f) Selected to ensure that when a test is administered to a student with impaired sensory, manual, or speaking skills, the test results accurately reflect the factor(s) the test purports to measure rather than reflecting the student's impaired sensory, manual, or speaking skills

(except where those skills are the factors the test purports to measure).

3. Nondiscriminatory intellectual assessment procedures must meet the following guidelines:

   a. Whenever it is necessary to conduct an individual intellectual assessment as a component of a diagnostic assessment, the examiner shall review all available pertinent information regarding the student, the student's family, and the socio-cultural background of the student.

      (1) If it can be clearly documented from this information that the student's background is representative of the socio-economic and socio-cultural heritage of the majority of the sample used in standardizing the intellectual assessment instrument to be used, the results of the instrument may be used directly.

      (2) In all other cases the Socio-Cultural Scales of the System of Multicultural Pluralistic Assessment (SOMPA) shall be used as a component of the evaluation.

   b. When the Socio-Cultural Scales are used, and when the student is 5 to 12 years of age and Anglo, Black, or Hispanic, the Estimated Learning Potential (ELP) shall be calculated and used as one indicator of intellectual abilities. A student may have an ELP above the range for retardation but still be retarded if there are sufficient data to indicate that the ELP is invalid. The examiner must take into account adaptive behavior, years in special education, home environment and family support, curriculum, language, and all other relevant factors when interpreting these scores.

   c. When the Socio-Cultural Scales are used and the student is outside the age range or ethnic groups of the SOMPA, the results of the standard intellectual measurement shall be interpreted by the psychologist taking the socio-cultural results into account.

APPENDIX F

INAPPROPRIATE REFERRAL CONCERNS

INAPPROPRIATE REFERRAL CONCERNS

1. Daydreaming
2. Poor attention
3. Poor school attendance
4. Easily distracted
5. Talks excessively out of turn
6. Acts before thinking
7. Clumsy and fidgety
8. Inability to remain on task
9. Difficulty following directions
10. Overly active
11. Easily excited
12. Short temper
13. Does not interact well with others
14. Academic performance fluctuates
15. Blurts out answers in class

APPENDIX G

ELIGIBILITY REQUIREMENTS

LEARNING DISABLED

ATTENTION DEFICIT DISORDER

DSM III - R

LEARNING DISABLED

I. DEFINITION

Learning Disabled means severe and unique learning problems as a result of significant difficulties in the acquisition, organization, or expression of specific academic skills or concepts. These learning problems are typically manifested in school functioning as significantly poor performance in such areas as reading, writing, spelling, arithmetic reasoning or calculation, oral expression or comprehension, or the acquisition of basic concepts.

The term includes such conditions as attentional deficit, perceptual handicaps, process disorders, minimal brain dysfunction, brain injury, dyslexia, developmental aphasia, or sensory-motor dysfunction, when consistent with these criteria.

The term does not include students who have learning problems which are primarily the result of visual, hearing, or motoric handicaps, mental retardation, a behavior disorder, or environmental, cultural, or economic disadvantage.

II. CRITERIA FOR ELIGIBILITY

Criteria A through G must all be met.

A. The learning problems are not due <u>primarily</u> to such factors as:

a. -lack of educational opportunity,
b. - emotional stress in the home or school,
c. -difficulty adjusting to school,
d. -curricular change or temporary crisis situations,
e. .other handicapping conditions,
f. environmental, cultural, or economic disadvantage, and/or
g. lack of motivation.

B. There must be evidence that the student, <u>after receiving supportive and remedial regular educational assistance</u>, still exhibits a learning disability consistent with the definition. <u>Students eligible for compensatory or remedial education programs shall receive assistance in these programs prior to being considered for special educational services</u>.

C. There must be evidence that the student, after receiving services in the Pupil Appraisal Assessment Program specific to the identified learning problems, exhibits a learning disability consistent with the definition. This evidence shall include, at a minimum, the results of the systematic measurement of the identified specific learning problems, conducted according to the procedures for evaluation, which indicate that the student's learning abilities are significantly impaired with respect to those of nonhandicapped students.

D. There must be evidence of a severe discrepancy between achievement and ability as demonstrated by a difference of at least one standard deviation between the student's strongest and weakest performance in academic areas described as follows:

1. A relative academic strength as demonstrated by performance no more than one standard deviation below the mean in grades 3 through 12 or one half standard deviation below the mean in grades K through 2 for the grade level appropriate for the child's chronological age in one or more of the areas listed under 2 below. The relative academic strength must, in addition, be at least one standard deviation higher than the lowest academic area identified in 2 below. The standard error of measurement may be considered in individual cases.

2. An academic deficit or deficits, as demonstrated by performance greater than one and one half standard deviations below the mean in grades K through 2, or two standard deviations below the mean in grades 3 through 12 for the grade level appropriate for the student's chronological age in one or more of the following areas. The standard error of measurement may be considered in individual cases.

   a. Reading recognition (basic reading skill),

   b. Reading comprehension,

   c. Math calculations,

   d. Math reasoning,

   e. Oral expression,

   f. Listening comprehension,

   g. Written expression (e.g., spelling), and

h. Other age-appropriate developmental skill areas when more appropriate for kindergarten students (e.g., preacademic skills).

III. PROCEDURE FOR SCREENING

General Screening Procedures shall be followed.

IV. PROCEDURES FOR EVALUATION

A. The Pupil Appraisal Assessment Program shall be conducted for students suspected of being Learning Disabled and shall include:

1. Sensory screening, if not previously conducted.

2. A review of the student's educational, social, and medical history, including the attendance record.

3. An interview with the student.

4. An interview with the student's teacher in order to specify and behaviorally define the areas of concern, determine the teacher's expectations for the student and class, and clarify any previous interventions.

5. A family interview conducted by a social worker or other appropriate pupil appraisal staff member to determine the impact of social, cultural, developmental, emotional, and/or health factors on the student's difficulties. The family interview should address such additional factors as:

   a. The parent's perception of the problem behavior;

   b. The expectations of the parents for the student in the home and school environments;

   c. Parental efforts to deal with the problem behavior at home and/or through community service contact;

   d. A determination of the student's strengths and weaknesses, relationships with peers and siblings, self-concept, and achievement motivation as perceived by the family; and

   e. Clarification of educational history information including attendance and other concerns of evaluation team members.

DSM III-R DEFINITION OF ATTENTION-DEFICIT HYPERACTIVITY DISORDER

Note: Consider a criterion met only if the behavior is considerably more frequent than that of most people of the same mental age.

A. A disturbance of at least six months during which at least eight of the following are present:

(1) often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)

(2) has difficulty remaining seated when required to do so

(3) is easily distracted by extraneous stimuli

(4) has difficulty awaiting turn in games or group situations

(5) often blurts out answers to questions before they have been completed

(6) has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fails to finish chores

(7) has difficulty sustaining attention in tasks or play activities

(8) often shifts from one uncompleted activity to another

(9) has difficulty playing quietly

(10) often talks excessively

(11) often interrupts or intrudes on others, e,g., butts into other children's games

(12) often does not seem to listen to what is being said to him or her

(13) often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)

(14) often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking

Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM-III-R criteria for Disruptive Behavior Disorders.

B. Onset before the age of seven.

C. Does not meet the criteria for a Pervasive Developmental Disorder.

CRITERIA FOR SEVERITY OF ATTENTION-DEFICIT HYPERACTIVITY DISORDER

Mild: Few, if any, symptoms in excess of those required to make the diagnosis and only minimal or no impairment in school and social functioning.

Moderate: Symptoms or functional impairment intermediate between "mild" and "severe."

Severe: Many symptoms in excess of those required to make the diagnosis and significant and pervasive impairment in functioning at home and school and with peers.

The new DSM also contains a residual category (**Undifferentiated Attention-deficit Disorder**) for disturbances in which the predominant feature is the persistence of developmentally inappropriate and marked inattention that is not a symptom of another disorder such as retardation or a disorganized, chaotic environment.

Diagnostic and Statistical Manual (Volume III-Revised): pages 52-53

APPENDIX H

ASSESSMENT INSTRUMENTS

ATTENTION DEFICIT DISORDER QUESTIONNAIRE

FOR PARENTS

DOES YOUR CHILD EXHIBIT THE FOLLOWING BEHAVIORS ?

		Almost Never				Almost Always
1.	Accidently runs into people and objects	1	2	3	4	5
2.	Difficulty getting to bed and sleeping	1	2	3	4	5
3.	Cannot be trusted	1	2	3	4	5
4.	Confuses telephone messages	1	2	3	4	5
5.	Loses things in the home	1	2	3	4	5
6.	Knows spelling words at home but forgets at school	1	2	3	4	5
7.	Difficulty getting started with homework	1	2	3	4	5
8.	Overly active since birth	1	2	3	4	5
9.	Prefers playing with younger children	1	2	3	4	5
10.	Gets into fights with siblings	1	2	3	4	5
11.	Destroys toys	1	2	3	4	5
12.	Complains of stomach problems	1	2	3	4	5
13.	Refuses to do chores or does not finish chores	1	2	3	4	5
14.	Runs excessively in public places such as the grocery store	1	2	3	4	5
15.	Does not sit still while watching T.V.	1	2	3	4	5

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16.	Interrupts conversations	1	2	3	4	5
17.	Prefers to be in own room alone rather than with family members	1	2	3	4	5
18.	Works well alone or with one adult on projects	1	2	3	4	5
19.	Doesn't take care of clothes	1	2	3	4	5
20.	Doesn't benefit from mistakes	1	2	3	4	5
21.	Totally different from siblings	1	2	3	4	5
22.	Wears a chip on shoulder	1	2	3	4	5

ATTENTION DEFICIT DISORDER RATING SCALE

	BEHAVIOR ITEM	Almost Never				Almost Always
1.	Difficulty following directions	1	2	3	4	5
2.	Needs constant supervision	1	2	3	4	5
3.	Wants immediate rewards	1	2	3	4	5
4.	Overly sensitive	1	2	3	4	5
5.	Questions authority figures	1	2	3	4	5
6.	Always in constant motion	1	2	3	4	5
7.	Difficulty concentrating of assigned task.	1	2	3	4	5
8.	Difficulty coming to attention	1	2	3	4	5
9.	Calls out excessively in class	1	2	3	4	5
10.	Fidgets excessively	1	2	3	4	5
11.	Changes from one task to another without completion	1	2	3	4	5
12.	Gives inappropriate responses to questions	1	2	3	4	5
13.	Appears not to think before acting	1	2	3	4	5
14.	Difficulty remaining attentive to assigned task	1	2	3	4	5
15.	Appears not interested in school work	1	2	3	4	5
16.	Does not try	1	2	3	4	5
17.	Isolated by classmates	1	2	3	4	5
18.	Difficulty adapting to new situations	1	2	3	4	5
19.	Argumentative and wants the last word	1	2	3	4	5

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LEARNING DISABILITY RATING SCALE

	BEHAVIOR ITEM	Almost Never				Almost Always
1.	Difficulty with expressive language	1	2	3	4	5
2.	Difficulty with receptive language	1	2	3	4	5
3.	Problem retaining spelling words	1	2	3	4	5
4.	Reverses letters and numbers	1	2	3	4	5
5.	Difficulty with reading recognition	1	2	3	4	5
6.	Difficulty with reading comprehension	1	2	3	4	5
7.	Poor listening comprehension	1	2	3	4	5
8.	Poor written expression	1	2	3	4	5
9.	Deficit with math reasoning	1	2	3	4	5
10.	Deficit in math calculations	1	2	3	4	5
11.	Reads from right to left	1	2	3	4	5
12.	Unorganized	1	2	3	4	5
13.	Poor coordination	1	2	3	4	5
14.	Short attention	1	2	3	4	5
15.	Hyperactivity	1	2	3	4	5
16.	Rushes to complete work	1	2	3	4	5
17.	Makes careless errors	1	2	3	4	5
18.	Does not try	1	2	3	4	5
19.	Difficulty with word tense	1	2	3	4	5
20.	Poor work attack skills	1	2	3	4	5
21.	Difficulty with naming common words	1	2	3	4	5
22.	Difficulty with sentence formation	1	2	3	4	5

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ATTENTION DEFICIT DISORDER QUESTIONNAIRE

FOR TEACHERS

DOES YOUR CHILD EXHIBIT THE FOLLOWING BEHAVIORS ?

		Almost Never				Almost Always
1.	Has trouble remembering things	1	2	3	4	5
2.	Is inattentive during assemblies and free time	1	2	3	4	5
3.	Does not finish assigned task but jumps to something else	1	2	3	4	5
4.	Is hyperactive and restless	1	2	3	4	5
5.	Has difficulty waiting turns	1	2	3	4	5
6.	Excessively out of seat	1	2	3	4	5
7.	Fidgets with items such as pencil, paper, etc.	1	2	3	4	5
8.	Stares into space during lecture	1	2	3	4	5
9.	Loses things such as homework, paper, pencil, place book	1	2	3	4	5
10.	Is easily distracted by outside activities	1	2	3	4	5
11.	Talks out of turn	1	2	3	4	5
12.	Becomes angry quickly and will attack teacher and peers	1	2	3	4	5

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13.	Assignments poorly written	1	2	3	4	5
14.	Does not work well in group activities	1	2	3	4	5
15.	Appears impatient with others	1	2	3	4	5
16.	Volunteers in class	1	2	3	4	5
17.	Appears immature in comparison to peers	1	2	3	4	5
18.	Impatient with self and others	1	2	3	4	5
19.	Academic performance fluctuates from day to day	1	2	3	4	5
20.	Steals of destroys possessions of others	1	2	3	4	5

EVALUATION FORM

1. Did the presentations give you an adequate understanding of Attention Deficit Disorder?

   _____ Yes. _____No.

   If No, please explain _____.

2. Did the presentations provide you with specific techniques that you can use with the child?

   _____ Yes. _____No.

3. What specific techniques are you planning to use with the child?

   _____

   _____

4. Would you like additional information?

   _____ Yes. _____No.

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CASE STUDY 1

KIM

Kim is an 8 year old 3rd grader who is having academic problems. She is considered spoiled and immature. Kim needs a lot of individualized attention in order to stay on task. She is slow to get actively involved in the assigned task before her. She has difficulty picking out the important information to which she should be attending to. She responds quickly and makes many errors. Because of repeated failures she appears to have given up. Her main problem appears to be in the area of mathematics - calculation and reasoning. She reverses numbers and calculate from left to right rather than from right to left. She appears to have good basic reading skills.

Would you refer this child to the Special Education Department?

_____**Yes** _____**No**

Why?_____

_____

_____

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CASE STUDY 2

RICARDO

Ricardo is an 11 year old 5th grader who is having academic problems. His attendance is considered good. He has difficulty with reading. He has poor word attack skills and he mispronounces words. He has difficulty copying work from the blackboard even though he sits on the front row. He is ambidextrous - using both right and left hands. He makes B's in math; however, he has difficulty with word problems. Ricardo doesn't pay attention in the classroom and is easily distracted by sounds. He does not completed his homework and often lies about it. He takes longer than his classmates to grasp a new concept even with repetition. He is slowly becoming frustrated.

Would you refer this child to the Special Education Department?

_____**Yes** _____**No**

Why?_____

_____

_____

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CASE STUDY 3

FELIX

Felix is a 6 year old first grader who is having academic problems. His attendance is considered good. Felix daydreams and stares out of the window during class time. He disturbs his classmates by teasing, provoking, fighting or interrupting. He occasionally walks around the room during class time. He completes very little of his classwork. He shifts from one uncompleted activity to another. He is inattentive and easily distracted; however he does pay attention when he is interested in the subject matter, for example, dinosaurs. He is the first to have his hand raised, whether he knows the answer or not. His report card grades are C's one six weeks and D's and F's the next. He appears disorganized and uncooperative. He has difficulty remaining in his seat for a long during of time.

Would you refer this child to the Special Education Department?

_____Yes _____No

Why?_____

_____

_____

Developed By Maxine Desselle, BCSW - 1989

CASE STUDY FOR PARENTS 1

KIM

Kim is an 8 year old who has been overly active since the day she was born. Her feelings are easily hurt, yet she says ugly things to others. Kim does not play well with others and prefers being alone. She makes friends easily but does not keep friends.

Kim is always getting into trouble because she acts before she thinks. She is immature for her age and prefer playing with younger children who are running, jumping and climbing. She is clumsy and often breaks things.

Kim always complains about her stomach on Fridays when she has to take a test. She is forgetful and misplaces things such as homework assignment and books.

WHAT CAN KIM'S PARENTS DO TO HELP HER?

1. Refer Kim to the special education department for an evaluation.
2. Take Kim to her pediatrician for possible medication.
3. Provide Kim with her own special quiet spot without distractions to do homework.
4. Tell Kim what you want her to do, not what you don't want her to do.
5. Reward Kim for remembering homework assignment and remembering to bring her books home.
6. All of the above

CIRCLE THE NUMBERS THAT YOU THINK WILL HELP KIM

Developed By Maxine Desselle, BCSW - 1989

CASE STUDY FOR PARENTS 2

FELIX

Felix, age 6, is the youngest of 4 children. He has always been different from his sisters and brother. He is irritable, overactive and moody. He picks and often start fights. He never keeps still even to watch cartoons. He has no fears and often gets into dangerous situations. This has resulted in bruises, bumps and trips to the hospital.

Felix is easily frustrated and has temper tantrums on a daily basis. He is aggressive and his parents have had several calls from the principal concerning his behavior.

Felix's parents are at their wits end.

WHAT CAN FELIX'S PARENTS TO DO HELP HIM?

1. **Refer Felix to the special education department for an evaluation.**
2. **Take Felix to his pediatrician for possible medication.**
3. **Reduce the amount of sugar Felix eats.**
4. **Build on Felixsstrengths rather than his weaknesses.**
5. **Tell Felix what you want him to do not what you don't want him to do.**
6. **All of the above.**

CIRCLE THE NUMBERS THAT YOU THINK WILL HELP FELIX.

Developed By Maxine Desselle, BCSW - 1989

CASE STUDY FOR PARENTS 3

RICARDO

Ricardo is a 10 year old fifth grader. He forgets his homework, and when he does remember his homework, he or his parents cannot understand the assignments because he writes so poorly. He cannot read his own handwriting. Ricardo is able to write well when he takes his time, but he is always in a hurry.

Ricardo appears never to listen to his parents. They will have almost finished with instructions for Ricardo to do a chore before he realizes they are speaking to him.

Ricardo will go over his spelling list and have it down pat, but the next morning he has forgotten it. Yet, he will remind his parents of something they did 2 or 3 years ago in detail.

WHAT CAN RICHARDO'S PARENTS DO TO HELP HIM?

1. **Refer Ricardo to the special education department for an evaluation.**
2. **Take Ricardo to his pediatrician for possible medication.**
3. **Speak slower to Ricardo and repeat directions.**
4. **Make sure that they are physically present and have eye contact before they begin to speak with Ricardo.**
5. **Encourage Ricardo to slow down and let his hand catch up with his brain when writing.**
6. **All of the above.**

CIRCLE THE NUMBERS THAT YOU THINK WILL HELP RICARDO

Developed By Maxine Desselle, BCSW - 1989

APPENDIX J

IN-SERVICE DIALOGUE

DIALOGUE FOR PARENTS

INTRODUCTION

We have invited you to come today to help you to help your child who may be having difficulties at home and at school because they don't pay attention. Such children sometimes have what is called an Attention Deficit Disorder. These children can learn, and it is not that they do not want to pay attention - - - they cannot pay attention.

WHAT IS ATTENTION DEFICIT DISORDER?

Attention Deficit Disorder causes children to have problems with everything in their lives - they families, teachers and other children at school and at play.

WHAT CAUSES ATTENTION DEFICIT DISORDER?

No one is quite sure but many doctors believe that children are somehow born this way. Sometimes from the time they are born they are always moving and hard to handle. Maybe someone in their family was that way as a child. More boys than girls have an attention deficit disorder. Some doctors believe that the unborn baby may have been exposed to harmful substances such as pollution or chemicals added to some foods. Whatever the cause, Attention Deficit children behave a lot alike.

PATTERNS OF BEHAVIOR

The attention deficit disordered child cannot pay attention to anything for very long and any little thing can distract him from what he should be doing. To get the child to finish a job someone must be near to watch and direct. Often parents find

themselves in endless battles, nagging constantly, "Finish your homework, finish the dishes, you didn't finish making your bed." Attention Deficit Disordered children are so distractible they literally seem to suspend their activity in mid-air, going on to something completely different, forgetting the job they have left undone or half completed (Murphy and Corte, 1987).

Attention Deficit Disordered children are extremely impulsive. "They want what they want when they want it." For example, taking other people's things without thinking of the rightfulness or wrongness of their actions, running into traffic to get a ball with no awareness of the dangers, inability to profit and learn from previous mistakes are all examples of behaviors that lead to troublesome family relations. Acting before thinking is coupled with punches, fist fights and constant arguments with sisters and brothers or playmates who refuse to play the game their way (Murphy and Corte, 1987). Thye have difficulty obeying rules or waiting for a turn, wanting whatever they want-NOW

The Attention Deficit Disordered child is disorganized

They are often unable to complete even simple chores on their own. They are sometimes not very neat - their shirt tails flapping, shoe laces untied, and they don't appear to care. **Attention Deficit Disordered children appear to be always on the move.** They seem driven by some constant inner need to touch, tap, fidget, squirm, push, knock over or kick. They act as if their body is in high gear at all times, with an inability to shift into low (Murphy and Corte, 1987).

As as infant they were poor sleepers, seldom napped, awoke at the slightest sound, slept fitfully and never through the night. This behavior often continued as they grow older.

As a toddler they were not only into everything but there appeared to be no reason for their non-stop activity. They didn't play with toys; they threw them or broke them. They tore books. They did not share or play well with others. They fidgeted, squirmed and sometimes raw away while you attempted to read a story. A child without Attention Deficit Disorder will sit quietly for at least short periods of time to color or put together a puzzle. A child with Attention Deficit Disorder is unable to play for more than a few seconds. Crayons are broken and puzzle pieces are lost as they move from one activity to another.

One mother described her child as "A disaster waiting to happen." (Murphy and Corte, 1987).

The major difference between the normal toddler and the hyperactive one is that the normal child is able to slow down, listen for direction and stop on his own.

During childhood - The Attention Deficit Disordered child continues to fidget, is unable to sit through a meal, or even watch a favorite T.V. program without roaming around the house. The teachers report to you that your child is unable to sit at his/her desk, speaks out of turn and bothers others.

Difficulties in coordination

Many Attention Deficit Disordered children are not as coordinated as other children their age. Throwing and catching

a ball are problems for them. Their hands and eyes do not seem to work together so that they appear clumsy. They have a lot of trouble in activities such as handwriting, coloring and cutting with scissors.

Demanding behavior

Attention Deficit Disordered children always demand to be in the spotlight at all times. Because they appear to need so much, and want so much - parents feel guilty and are tempted to pay for peace at any price. However, this only makes the child demand more. Parents and brothers and sisters find themselves unable to control the child. The footstomping, whining, into everything toddler becomes the annoying demanding show-off child or teenager who always wants the last word.

Attention Deficit Disordered children insist on being first in line at school and served first at the dinner table at home. Games must be played their way. They are often known as bullies on the playground and in the neighborhood. They upset others to the point where they have no friends their age. They often play with younger children who are more likely to put up with their bossiness (Murphy and Corte, 1987).

They have poor judgement or none at all. They appear to have no fears; they swing from trees, play near railroad tracks and pick at animals to the point of danger.

Attention deficit disordered children appear happy one minute and off into space the next with a sad face for no know reason. They are overly excitable and short-fused.

The behaviors of Attention Deficit Disordered children result in a world of no friends because they are "different." They feel worthless, that they can't do anything right; they dislike themselves and others and think everyone is against them.

What can parents do?

MEDICAL TREATMENT - Dr. Thomas Jones in Opelousas is a specialist with Attention Deficit Disordered children. He can diagnose whether your child has an Attention Deficit Disorder. He can design a course of treatment and can watch your child to make sure he is being helped.

Medication is often indicated but a pediatrician - a doctor who is specially trained to treat children is the expert. The best attitude to have about medication is that Attention Deficit Disorder with hyperactivity is a physical problem and sometimes medicine is required to control this disorder. BUT remember medication is not a "quick fix."

Diet - Special diets have claimed to help hyperactive children. Sugar, food dyes and other artificals are suggested to be removed from the child's diet. Hot dogs, lunch meat, sugary cereals, popsicles, soft drinks, kool-aid and candy - foods like these should be avoided. Again it is best to seek advice from a pediatrician. However, a balanced diet, low in sugar and fat, but with plenty of fresh fruits, vegetables, whole grain products, lean meats, fish and milk should benefit not only the attention deficit disordered child but the whole family.

Do's and Don'ts

Teach self control

Don't say "Tom can't help it; he's hyperactive". That will only reinforce inappropriate behaviors.

Do - make rules that are easy to understand and stick to the rules. Don't start with too many rules. For example, homework must be done at 4:00 each day.

Do - praise any imporvements. Show your love but be strict. This is easier said than done, I know, (Tell about Felix)

Do - Try to find something for which to praise your child. Find a simple activity your child enjoys and can do well to praise him. To solve school problem you must talk with the teacher. Have a daily report card with privileges dependent upon good behavior is important. (Tell about Felix)

Most attention deficit disordered children function best with one person at a time, free from distractions - No T.V. You must organize, plan, supervise and provide the structure he cannot organize on his own such as packing his booksack.

Do - Get your child into activities that will burn up some of his energy, especially during the summer. For example, running, bike riding and swimming are good even for the "clumsy" child. Maybe your child can't play baseball or basketball because his hands and eyes don't work together and failure just makes him unhappier. Competition and team sport may not be best for your child.

Do - be aware that these children may not feel pain as much as

they should and may be cut or bruised without really noticing it. (Tell about Felix Barbeques puppy). Remember if you get excited about little injuries, the child will learn to get attention that way.

Do - keep noise down when they child does homework. Household appliances, T.V., even people's laughter will distract the child enough to start a temper tantrum.

Do - have a regular schedule for dinner, bedtime, homework and chores. You can put a schedule on the refrigerator.

Don't - overload the child with too many things at once. For example, "make you bed, get dressed, come and eat breakfast, we're leaving soon," is too much for the child to handle. Select one activity at a time, give supervision and praise for successful completion of a simple task. (Murphy and Corte, 1987)

Do - involve the whole family, sisters, brother, grandma, grandpa, aunts and uncles. Explain the situation and get them to help by not changing the rules or schedule. Don't let Uncle Joe say the child can stay up late.

Don't - think these children have learning problems that the Learning Disability Program with Special Education can help. They can learn just as well as any child once they have learned to be still and pay attention.

DO ANY OF YOU RECOGNIZE ANY OF THESE BEHAVIORS WITH YOUR CHILD?

Dialogue for Teachers In-service

The purpose of this in-service is to improve your knowledge regarding Attention Deficit Disorder, criteria for Learning Disability and intervention techniques that you can use in the classroom for children who demonstrate characteristics of Attention Deficit Disorder.

I know that it is frustrating when you refer a child for special education services and the evaluation indicates no exceptionality. The most difficult child to recognize is the one with a specific learning disability that is also hyperactive. This child may have an Attention Deficit Disorder with hyperactivity that is interfering with his academic performance. Children with attention problems present a wide group of difficulties in the classroom.

Attention Deficit Disorder is a tern used to describe a group of children who have many problems in common. Most have one or more learning disabilities that interfere with their school and social activities. These will be described in detail later. Many will be hyperactive and/or distractible with a short attention span. Most develop emotional, social and family problems because of frustrations and failures they experience. Each child will have different combinations of these problems; all children with Attention Deficit Disorder are not identical.

Parents come to you who are the professionals, for help with their child's learning problems. Sometimes you refer the child to the Special Education Department; however,

Special Education is not the answer for the Attention Deficit Disordered Child. Both you and the parents become frustrated because there seem to be nowhere to turn. This is the reason we are meeting today and why I will also be meeting with the parents in the weeks to come.

Today, Dr. Thomas Jones will give us an overview of Attention Deficit Disorder and clarify and misconceptions regarding medication. In the following weeks, I will work with you individually in order to provide detailed interventions for specific children in your classroom. I will provide examples of 3 short study cases unique to Attention Deficit Disorder and Learning Disability for you to examine. In 3 months, you will be able to recognize problems associated with Attention Deficit Disorder, understand the various causes and know the different approaches to treatment.

APPENDIX K

LETTER TO PARENTS

Dear Parents,

We at your school know that parents and teachers today need to work together to help our students. You are invited to have coffee and doughnuts at our cafeteria where there will be a presentation and discussion of ways we can help some of our students who may need help in such areas as paying attention, doing homework and so forth.

We look forward to seeing you on_____ _____ _____ at _____.

Sincerely,

Maxine Desselle, B.C.S.W.